

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16911

State File No. ....

Registrar's No. 2177

FILED JUN 7 1949  
Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3418 Wabash  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 36 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs. Adah B. Duff

3. (b) If veteran, No name war  
3. (c) Social Security None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife James R. Duff 6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased September 7 1868  
(Month) (Day) (Year)

8. AGE: Years 74 Months 8 Days 2 If less than one day hr. min.

9. Birthplace Louisville Kentucky  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business

12. Name Andrew Beard  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Charles Downey

(b) Address 5432 Baltimore

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-11-1943  
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington Cemetery

18. (a) Signature of funeral director Freeman Mortuary

(b) Address Kansas City, Mo.

19. (a) 5-11-43 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3418 Wabash  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9  
year 1943 hour 3 minute 30 P. M.

21. I hereby certify that I attended the deceased from 1935 to 1943  
that I last saw him alive on May 8 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death HEART DISEASE

Due to 48 B

Due to

Other conditions PROBABLE CANCER UTERUS  
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur?  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury

23. Signature A. C. Dineen (M.D. or other)  
Address Green Campus, W. Mo. Date signed May 10 1943

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

1-4  
for 4 1936  
for 4 1936  
for 4 1936  
for 4 1936

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Clarence H. Chiles

Licensed Embalmer No. 3473

P. O. Address Keeno

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**